

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151334	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SURGERY ADDITION B. WING _____		(X3) DATE SURVEY COMPLETED R 08/17/2015
NAME OF PROVIDER OR SUPPLIER SCOTT MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 1451 N GARDNER ST SCOTTSBURG, IN 47170		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Validation Survey conducted on 05/19/15 was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b).</p> <p>Survey Dates: 08/17/15</p> <p>Facility Number: 004778 Provider Number: 151334 AIM Number: 100268930A</p> <p>At this PSR survey, Scott Memorial Hospital was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 482.41(b), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies for the 2007 surgery addition.</p> <p>The facility was constructed at two different times. The original building is a one story, sprinkled building of Type II (222) construction. In 2007, a one story addition to the southwest of the original building was constructed and is a one story, sprinkled addition of Type II (222) construction. The original building was surveyed with NFPA 101, LSC, Chapter 19, Existing Health Care Occupancies and the 2007 surgery addition was surveyed with NFPA 101, LSC Chapter 18, New Health Care Occupancies. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detection in all patient sleeping rooms. The facility has a capacity of 25 and had a census of 6 at the time of this survey.</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.